Orapuh Journal

OPEN ACCESS

ORIGINAL ARTICLE

Journal of Oral & Public Health

Walking the Tightrope: Exploring Nurses' Perceptions of End-of-Life Care in a South African Academic Hospital

Maphake, D.

Department of Nursing, Faculty of Health Sciences, Sefako Makgatho Health Sciences University, Pretoria, South Africa

ARTICLE INFO

Received: *08 July 2026*
Accepted: *28 August 2026*
Published: *11 November 2026*

Keywords:
End-of-life care, emotional stress, burnout, palliative care, academic hospital, Roy Adaptation Model

Peer-Review: *Externally peer-reviewed*

© 2026 The Author.

Re-use permitted under CC BY-NC 4.0
No commercial re-use or duplication.

Correspondence to:
Dikeledi Maphake
dikeledi.maphake@smu.ac.za

To cite:
Maphake, D. (2026). Walking the tightrope: Exploring nurses' perceptions of end-of-life care in a South African academic hospital. *Orapuh Journal, 7*(10), e1496
https://doi.org/10.4314/orapj.v7i10.96

ISSN: *2644-3740*

Published by ***Orapuh, Inc.***, F. Gaye Res., Sukuta-Jamisa, Greater Banjul, The Gambia.

Editor-in-Chief: *Prof. V. E. Adamu (editor@orapuh.org)*

ABSTRACT

Introduction

End-of-life care demands a patient-centred, empathetic approach. In academic hospital settings, nurses frequently encounter profound emotional stress and occupational burnout driven by caring for high volumes of terminally ill patients. These psychological burdens, combined with adverse working environments, frequently compromise care delivery, precipitate mental health challenges, and aggravate resource deficits.

Purpose

This qualitative study explored nurses' perceptions and lived experiences regarding end-of-life care delivery at an academic hospital in the Gauteng province of South Africa.

Methods

The study was conducted in specialized inpatient care units within a major academic teaching hospital in northern Pretoria, Gauteng province. A qualitative, descriptive design was utilized. Purposive sampling was employed to recruit twenty-four (n = 24) professional, enrolled, and auxiliary nurses who had direct experience providing end-of-life care. Data were gathered through face-to-face, semi-structured interviews guided by an open-ended interview schedule. All sessions were audio-recorded, transcribed verbatim, and analyzed using Braun and Clarke's thematic analysis framework. Rigour was maintained through established qualitative criteria, and the analysis was interpreted through the lens of Callista Roy's Adaptation Model.

Results

Data analysis yielded two primary themes: (1) *Emotional turmoil*, capturing subthemes of grief and guilt stemming from intense therapeutic bonds and patient mortality; and (2) *Institutional challenges*, encompassing subthemes of understaffing, lack of psychosocial support systems, poor physical infrastructure, and deficiencies in staff development and training.

Conclusion

Academic hospital nurses are strongly motivated to deliver compassionate palliative care but face significant structural and psychological barriers. Healthcare legislators and hospital management must establish targeted educational curricula, improve staffing ratios, and scale up institutional mental health support services to safeguard nursing well-being and elevate palliative care quality.

INTRODUCTION

End-of-life (EOL) care is a core component of comprehensive clinical healthcare that demands patient-centred, empathetic, and holistic practices. Registered and enrolled nurses occupy a central position in delivering this specialized care (De Brasi et al., 2021). As the primary point of contact among patients, grieving families, and the multidisciplinary healthcare team, nurses bear substantial clinical and psychological responsibilities. Despite their pivotal role, critical gaps remain in understanding their frontline experiences and perceptions of EOL care, particularly within complex academic hospital environments. Palliative care places severe emotional and personal demands on nursing personnel, triggering chronic stress, anxiety, and professional burnout (Clayton & Marczak, 2023). The meaning and psychological weight of these experiences are heavily mediated by the depth of the nurse-patient therapeutic relationship.

The escalating global prevalence of chronic, life-limiting illnesses has magnified the demand for skilled nursing interventions during the terminal phase; however, healthcare institutions frequently operate under severe resource constraints (Jung & Matthews, 2021). Consequently, nurses confront systemic obstacles that threaten their occupational well-being and clinical efficacy (Üstükuş & Eskimez, 2021). By virtue of continuous bedside contact, nurses providing EOL care forge deep relational bonds with their patients (Jung & Matthews, 2021). Conversely, when nurses recognize that patients are entering the terminal phase, psychological defense mechanisms or emotional withdrawal can occur, inadvertently heightening workplace anxiety and existential distress (Xu et al., 2022).

Nurses often serve as the primary and final line of clinical treatment throughout acute hospital admissions (Molefe, 2024). Although their dedication remains steady regardless of years of service, susceptibility to feelings of powerlessness, profound empathy, and sorrow leaves them vulnerable to depression, anxiety, and eventual burnout following sudden patient mortality (Cybulska et al., 2022). Because death and dying are daily occurrences in acute care facilities, witnessing prolonged suffering and patient mortality constitutes cumulative occupational trauma that deteriorates mental health and impairs the execution of quality death care (Onah & Oriekwo, 2024). Despite taxing practice environments, individual nurses frequently derive intrinsic motivation from factors such as professional pride, maintained job satisfaction, and a commitment to patient dignity (Young & Roos, 2024). The immediate practice environment profoundly shapes professional quality of life. Workplace psychosocial and structural characteristics exert significant direct effects on nurses' biopsychosocial well-being (Zhang et al., 2024). Both interpersonal dynamics and organizational structures in clinical units can either foster professional fulfillment or induce severe moral distress (Clayton & Marczak, 2023). As the complexity and volume of palliative care needs rise, nurses frequently report sleep disturbances, somatic complaints, and psychological difficulties including moral injury and depression.

In the face of inconsistent healthcare delivery, sub-optimal pain management, and scarce emotional support, the delivery of high-quality EOL care remains a persistent global challenge. Mitigating these deficits is particularly difficult in resource-constrained settings where service demands steadily escalate (Shepherd, 2025). Navigating patient mortality without adequate institutional support breeds personal doubt, guilt, and a loss of professional confidence. Furthermore, institutional barriers such as inadequate training, material shortages, and administrative indifference impede the delivery of dignified palliative care (Paterson & Maritz, 2024).

Against this backdrop, this study explored the perceptions and lived experiences of nurses delivering end-of-life care within an academic hospital in the Gauteng province of South Africa, utilizing Callista Roy's Adaptation Model to frame the structural and psychological dynamics observed.

Theoretical Framework

This study was anchored in Callista Roy's **Roy Adaptation Model (RAM)**, which conceptualizes human beings as holistic adaptive systems that continually respond to internal and external environmental stimuli across four adaptive modes: physiological-physical, self-concept, role-function, and interdependence (Roy, 2009; Roy & Andrews, 1999). Nurses operating within palliative and EOL care settings face continuous emotional, ethical, and

professional stimuli, including managing dying patients, counseling grieving families, and processing frequent patient deaths. According to the RAM framework, these clinical encounters represent focal, contextual, and residual stimuli that demand active adaptive coping mechanisms to preserve psychological integrity, professional competence, and emotional health.

The RAM framework provides a robust lens for examining how nurses perceive, process, and react to the immense demands of EOL care, seeking adaptive responses that foster personal well-being alongside excellent patient care. Specifically, the model evaluates nurses' emotional adaptation, professional resilience, and adjustment to demanding environments. Competence in regulating grief, mitigating emotional distress, and maintaining therapeutic boundaries reflects successful emotional adaptation to frequent exposure to death and dying. Furthermore, the model elucidates adaptive coping strategies—such as seeking peer support, engaging in reflective practice, drawing on personal spirituality, and utilizing professional experience to process cumulative grief.

By applying the RAM framework, this study investigates the environmental factors that either facilitate or constrain nurses' adaptive capabilities, ultimately informing targeted interventions to foster supportive clinical practice environments.

Literature Review

Palliative care nursing exposes practitioners to profound psychological, spiritual, and physical stressors. These cumulative impacts disrupt personal routines and diminish empathetic capacity in relational spheres outside the workplace, including interactions with family and friends (Baqutayan, 2015). Prolonged and frequent exposure to dying patients degrades an individual's stress-coping reservoirs if adequate restorative mechanisms are absent.

Following a patient's death, nurses actively search for restorative and protective behaviors to replenish their emotional energy. These restorative practices include physical exercise, spiritual or religious participation, and recreational pursuits (Nacak & Erden, 2022). Furthermore, professional counseling, attending memorial services, and engaging in reflective discussions with colleagues facilitate emotional closure and acceptance, helping nurses reframe patient death as a natural, inevitable biological process beyond individual control (Nacak & Erden, 2022).

While extensive historical research has evaluated the impact of palliative care on patients and their families, investigating its direct psychological toll on nursing personnel remains imperative (Clayton & Marczak, 2023). Palliative nursing is uniquely taxing due to the prolonged, intimate therapeutic relationships established with patients, particularly in primary and specialized care settings where nurses function as central coordinators over extended admissions (Limbu & Taylor, 2021).

Chronic occupational stress and fatigue driven by frequent patient mortality generate physical and mental instability, frequently culminating in absenteeism and professional attrition (Alshammari et al., 2022). Many nurses experience profound powerlessness and moral distress when confronted with clinical problems they cannot resolve. Paterson and Maritz (2024) observed that when institutional constraints prevent nurses from delivering their desired standard of care, professional confidence erodes. Impaired interprofessional communication further compromises the continuity of compassionate palliative care (De Brasi et al., 2021).

Occupational burnout is widely documented as a critical systemic hazard in resource-limited healthcare systems (Barnard et al., 2023). High workloads, severe understaffing, organizational deficits, and high-stress clinical environments culminate in emotional exhaustion and depersonalization. Across Sub-Saharan Africa, nursing burnout rates are exceptionally high (Owuor et al., 2020). In South Africa, burnout is exacerbated by extreme work demands and deteriorating physical working conditions (Barnard et al., 2023). However, existing literature primarily addresses general occupational burnout rather than the specific emotional sequelae of managing dying patients. Furthermore, empirical data regarding how frequent exposure to death, family communication dynamics, and moral distress impact teaching and specialized referral roles in academic hospitals—particularly within Gauteng—remain scarce. This literature gap necessitates context-specific qualitative research exploring nurses' lived experiences of EOL care.

Regardless of clinical tenure, nurses experiencing prolonged psychological distress exhibit physical strain, moral discomfort, anxiety, and insomnia (Kostka et al., 2021; Kim et al., 2021). Palliative care delivery routinely exposes clinicians to distressing prognoses, trauma, and uncertainty. Beyond direct patient care, nurses shoulder the burden of supporting grieving families under adverse conditions.

Despite the establishment of institutional support structures, nurses continue to experience profound psychological and physical suffering, including anger, depression, fatigue, and occupational reevaluation (Kim et al., 2021). Identifying specific workplace stressors and determining the exact environmental factors that hinder or facilitate nurse well-being is vital for designing effective clinical interventions (Limbu & Taylor, 2021).

Studies indicate that affected nurses rely heavily on peer support networks to mitigate burnout, finding unique solace in colleagues who share identical clinical trials (Clayton & Marczak, 2023). Moses et al. (2024) noted that structural strategies—such as increasing staffing complements, streamlining administrative burdens, enhancing compensation, and providing formal recognition—significantly reduce occupational stress. While familial support is beneficial, external support systems often lack an understanding of acute clinical realities. Consequently, overcoming systemic challenges requires addressing heavy workloads, institutional indifference, and a clinical culture that frequently avoids open dialogue regarding death and dying (Jung & Matthews, 2021).

METHODS

Research Design

A qualitative, explorative, and descriptive design was adopted to investigate nurses' perceptions and experiences regarding EOL care delivery. This design enabled the capture of rich, in-depth empirical data reflecting the lived realities of nursing professionals within an academic hospital setting in Gauteng, South Africa (Grove et al., 2019).

Research Setting

The study was conducted within specialized inpatient wards of a major academic teaching hospital located in northern Pretoria, Gauteng province. Operating as a principal clinical training platform for Sefako Makgatho Health Sciences University, the facility possesses a bed capacity of 1,650 and serves as a major tertiary referral center for Gauteng, Northwest, Mpumalanga, and Limpopo provinces. The facility provides diverse specialized services including oncology, trauma, and critical care. This setting offers a unique environment for EOL care, blending advanced medical technology, complex clinical acuity, undergraduate and postgraduate clinical teaching, and active health research. Consequently, nurses in this environment must balance complex patient care with the supervision of nursing students and multidisciplinary collaboration amidst high patient volumes.

Study Population and Sampling

The study population comprised all professional, enrolled, and auxiliary nurses assigned to clinical units managing terminally ill patients. Non-probability purposive sampling was utilized to select twenty-four (n = 24) nursing participants. Inclusion criteria required participants to have a minimum of two years of clinical experience working in wards admitting terminally ill patients and to have provided written informed consent. Both day-shift and night-shift nursing staff on duty during data collection were eligible, irrespective of age, gender, or race.

Data Collection

To guarantee voluntary participation and prevent coercion, recruitment flyers were distributed with the assistance of operational unit managers; however, these managers were strictly excluded from participant selection and remained unaware of individual participation decisions. The flyers explicitly emphasized that participation was completely voluntary, withdrawal could occur at any time without penalty, and refusal would not impact employment status, professional standing, or performance appraisals. Interested nurses contacted the primary researcher directly. Following ethical clearance from the Sefako Makgatho Health Sciences University Research and Ethics Committee (SMUREC), formal administrative approval was secured from the hospital chief executive officer.

Data were collected using a semi-structured interview guide containing open-ended questions designed to explore nurses' opinions, emotional responses, and coping

strategies regarding EOL care. Probing techniques were utilized to elicit deeper narrative depth following patient deaths. In-person interviews were conducted in English within a private, distraction-free hospital office to ensure confidentiality. Interviews were audio-recorded with explicit participant consent. Data saturation—determined when no new thematic insights emerged—was initially anticipated between 15 and 20 participants. Saturation was formally reached after 18 interviews; however, the researcher continued interviewing an additional 6 participants (totaling n = 24) to verify data saturation and confirm thematic redundancy.

Data Analysis

Audio recordings were transcribed verbatim and analyzed using Braun and Clarke's six-step thematic analysis framework:

1. *Data familiarization:* Repeated reading of transcripts to immerse in the data and capture overarching meanings.
2. *Generating initial codes:* Systematic coding of interesting data features across the entire dataset relevant to the research question.
3. *Searching for themes:* Collating codes into potential overarching themes and gathering all relevant data extracts.
4. *Reviewing themes:* Checking candidate themes against the coded extracts and the entire dataset to generate a reliable thematic map.
5. *Defining and naming themes:* Ongoing refinement and generation of clear definitions and concise titles for each theme.
6. *Producing the report:* Compiling the analytical narrative with compelling data extracts linked back to research objectives and theoretical frameworks.

Trustworthiness

Trustworthiness was rigorously maintained using the criteria of Lincoln and Guba (1985): *credibility* was established through prolonged engagement and member checking; *transferability* was supported by detailed contextual descriptions of the research setting and participant demographics; *dependability* was ensured via an explicit audit trail of the research process; and *confirmability* was maintained by reflexive journaling and independent coding verification.

Ethical Considerations

Ethical approval was granted by the Sefako Makgatho Health Sciences University Research and Ethics Committee (Protocol: SMUREC/H/238/2025). Institutional authorization was obtained from the hospital CEO. Written informed consent was secured from all participants prior to data collection. Principles of autonomy, beneficence, non-maleficence, and justice were strictly upheld (Brink et al., 2018). Participants were assured of their right to withdraw at any stage without consequence. Anonymity and confidentiality were protected by assigning alphanumeric pseudonyms *(e.g., Participant 1, Nurse A)* to all transcripts and reports, and restricting data access to the primary investigator.

Demographic Characteristics of Participants

Table 1:
Demographic Characteristics of Participants (N = 24)

Demographic Variable	Category	Frequency (n)	Percentage (%)
Years of Experience	5–10 years	13	54.2
	11–20 years	4	16.7
	21–30 years	7	29.1
Gender	Female	14	58.3
	Male	10	41.7
Age	25–35 years	8	33.3
	36–45 years	7	29.2
	46–55 years	5	20.8
	> 55 years	4	16.7
Professional Qualification	Bachelor's degree (Professional Nurse)	6	25.0
	Diploma (Professional Nurse)	5	20.8
	Master's Degree (Professional Nurse)	2	8.3
	Higher Certificate (Enrolled Nurse)	3	12.5
	Auxiliary Certificate (Nursing Auxiliary)	8	33.4

RESULTS

Table 2:
Overview of Themes and Subthemes Emerging from the Qualitative Analysis

Themes	Subthemes
1. Emotional Turmoil	1.1 Feelings of grief
	1.2 Feelings of guilt
2. Institutional Challenges	2.1 Understaffing
	2.2 Lack of support for distressed staff members
	2.3 Poor infrastructure
	2.4 Poor staff development

Theme 1: *Emotional Turmoil*

Participants articulated that providing continuous care to terminally ill patients creates severe psychological exhaustion. Cumulative exposure to patient suffering and mortality frequently induces profound personal grief, guilt, and moral distress.

Subtheme 1.1: *Feelings of grief*

Participants described persistent feelings of loneliness, sadness, and emotional emptiness following the death of patients with whom they had established long-term therapeutic bonds.

"*Each time I came on duty, I pictured her there… she liked to sit on the chair in that corner facing the entrance. You know, looking and smiling at me.*" **(Participant 3, Professional Nurse)**

"*It's hard not to fall in love with the person who has been under your care for the past six months, and when they pass on… you feel like you no longer want to get close to anyone ever again!*" **(Participant 11, Enrolled Nurse)**

Subtheme 1.2: *Feelings of guilt*

Nurses expressed acute self-reproach regarding perceived shortcomings in time management and failure to provide sufficient attention during patients' final hours.

"*I feel like I never had enough time to prepare for her departure. The experience leaves you empty… If only I knew that it was her last day on this planet, I would have spent more time with her and listened more.*" **(Participant 7, Professional Nurse)**

"*You feel like you could have done more for them.*" **(Participant 19, Nursing Auxiliary)**

Theme 2: *Institutional Challenges*

Participants highlighted structural and organizational impediments within the academic hospital environment that exacerbated their emotional burden and hindered effective EOL care delivery.

Subtheme 2.1: *Understaffing*

Severe personnel shortages forced nurses to prioritize rigid administrative and clinical routines over meaningful psychosocial engagement with dying patients.

"*You must follow the ward routine and make sure that you perform your delegated duties. At times you come to work only to find that half of the staff are absent… That alone means that the patient care will definitely be affected. Think about all the death cases that might occur in such a short-staffed ward, let alone all the normal routine activities scheduled.*" **(Participant 2, Professional Nurse)**

"*In this ward it's normal to be six on duty. Imagine with a ward full of thirty patients.*" **(Participant 15, Professional Nurse)**

Subtheme 2.2: *Lack of support for distressed staff members*

Participants reported that institutional psychosocial support services were severely inadequate relative to staff needs, impeding proper mourning and recovery.

"*There is only one psychologist for all the nurses in this hospital. Now tell me, is that sufficient? Sometimes you are not able to take time off work to go and mourn properly due to this shortage.*" **(Participant 8, Professional Nurse)**

"*Many times, we come to work even though we are not feeling well, but just because we know that the situation is bad at work concerning the shortage.*" **(Participant 14, Enrolled Nurse)**

Subtheme 2.3: *Poor infrastructure*

Physical ward layouts lacked private spaces, compromising patient dignity and family privacy during terminal phases and bereavement.

"*The wards do not have private rooms where we can conduct interviews with the patients privately. We do not talk with them satisfactorily. Sometimes the patient is emotional, crying, and there is just no privacy to address sensitive issues with them.*" **(Participant 5, Professional Nurse)**

"*Some family members become hysterical over the loss of a loved one, and the ward does not have sufficient space to offer them privacy to cry, mourn, and comfort each other.*" **(Participant 22, Nursing Auxiliary)**

"*There are times when we have a corpse in the ward, and you can only draw the curtains around the bed closed because the side room is occupied.*" **(Participant 12, Professional Nurse)**

Subtheme 2.4: *Poor staff development*

Participants reported a conspicuous absence of formal in-service palliative care and communication training, leaving them feeling professionally incompetent when managing terminal events.

"*Maybe if we were taken to study courses that prepare you for the terminal phase of human life, like counseling.*" **(Participant 17, Enrolled Nurse)**

"*I mean, I can put up a drip and administer medication, but I am not trained on how to deal with a spouse whose partner has just stopped breathing!*" **(Participant 4, Professional Nurse)**

"*Maybe if the managers can plan training for us, especially the staff nurses and auxiliary nurses who did not study psychology back at college!*" **(Participant 20, Nursing Auxiliary)**

DISCUSSION

Emotional Turmoil

The findings of this study indicate that the emotional suffering of nurses—characterized by escalating grief and guilt—is not an isolated individual psychological phenomenon. Rather, it is fundamentally interconnected with a wider institutional context that dictates their capacity to adapt (Roy & Andrews, 1999). Interpreted through Callista Roy's Adaptation Model, these two emergent themes are deeply linked, wherein institutional failures function as contextual and residual stimuli that exacerbate the primary stressor of repeated patient deaths (Roy, 2009). According to RAM principles, successful adaptation depends on the individual's dynamic interaction with their environment. In this study, the clinical environment was characterized by severe understaffing, limited psychological support, inadequate physical infrastructure, and deficient staff training. Within this framework, a lack of professional preparation constitutes a major barrier to adaptive coping (Qutishat, 2025; Roy & Andrews, 1999).

Emotional withdrawal was clearly evident among participants who reported feeling empty and resolved "*you no longer want to get close to anyone ever again*" (Roy, 2009; Roy & Andrews, 1999). The adaptive sphere most heavily compromised is the **interdependence mode**, which focuses on relational interactions involving the giving and receiving of love, respect, and nurturing (Roy & Roberts, 1981). The presence of only a single clinical psychologist for thousands of hospital staff members, coupled with denied leave for mourning and absent bereavement debriefing structures, reflects a systemic lack of relational nurture within the institution (Qutishat, 2025; Roy & Andrews, 1999). While the focal trigger is repeated exposure to patient mortality, institutional deficiencies transform natural grief responses into maladaptive patterns of chronic fatigue, depression, guilt, and sadness (Roy, 2009).

In accordance with Roy and Roberts (1981) and Roy and Andrews (1999), adaptation is governed by environmental factors that either facilitate or constrain coping mechanisms. This confirms that maladaptive responses cannot be viewed solely as individual personal failures, but rather reflect an environment that systematically undermines available coping resources. Without adequate organizational support, nurses remain highly vulnerable to secondary traumatic stress, compassion fatigue, and diminished job satisfaction (Roy, 2009). When environmental support is inadequate, the cognitive-emotive subsystem becomes overwhelmed, preventing nurses from achieving integration, which Roy defines as successful adaptation to internal and external demands (Roy, 2009; Roy & Andrews, 1999).

Institutional Challenges

Institutional failures routinely undermine adaptive responses across all four of Roy's adaptive modes (Roy, 2009). Severe understaffing forces nurses to work while physically unwell and neglect personal self-care needs, aggravating cumulative grief and exhaustion within the *physiological-physical mode* (Bloomer et al., 2023; Roy & Andrews, 1999). Furthermore, nurses who experience acute guilt and believe they "*could have done more*" suffer erosion of their *self-concept mode*. Deficient palliative care training exacerbates this vulnerability by making nurses feel professionally incompetent when managing terminal events (Qutishat, 2025; Roy, 2009). This aligns with the RAM conceptualization that the self-concept mode is highly responsive to environmental feedback; without institutional preparation, nurses internalize systemic limitations as personal inadequacy (Roy & Andrews, 1999).

Understaffing and poor infrastructure restrict opportunities for meaningful patient engagement, private counseling, and dignified family interactions, thereby disrupting the *role-function mode*. This forces nurses to function merely as task-oriented technicians—focusing narrowly on procedures such as "*put up a drip and administer medication*"—rather than holistic caregivers (Roy, 2009). This role compromise exemplifies Roy and Andrews's (1999) and Dixon's (1999) proposition that adaptive role performance depends upon adequate professional competence and contextual support.

To restore biopsychosocial integrity, interventions must target environmental stimuli and contextual factors rather than merely admonishing individual nurses (Roy, 2009; Dixon, 1999). Targeted institutional reforms—such as optimized nurse-patient staffing ratios, formal certification in palliative care and counseling, expanded psychological support services, peer-supported debriefing sessions, and infrastructure upgrades providing private counseling and mourning spaces—can break the cycle of burnout, moral distress, and compromised patient care (Qutishat, 2025; Roy, 2009). Such measures foster positive self-concept, optimize role functioning, and restore the interdependence mode (Roy & Andrews, 1999).

Limitations of the Study

This study focused exclusively on nurses providing EOL care in specialized inpatient wards, excluding other members of the multidisciplinary team (such as physicians, social workers, and chaplains). Consequently, findings cannot be directly generalized to other clinical settings or non-academic institutions. Potential self-report biases, including recall bias and social desirability, may have influenced responses concerning emotionally sensitive topics. Furthermore, linguistic variations and differences in participants' ability to articulate complex emotional phenomena may have impacted data depth. To mitigate these limitations, the researcher utilized clarifying probes, established robust rapport, conducted interviews in secure private spaces, and maintained reflexive oversight throughout data collection and thematic analysis.

Implications for Nursing Practice

The findings underscore the urgent need to enhance nurses' psychological resilience, educational preparedness, and adaptive capacity in EOL care. Clinical governance structures must integrate structured psychological support, peer-led support groups, reflective practice forums, and routine clinical debriefing sessions into daily hospital operations. Ongoing, mandatory professional development in palliative care, symptom management, and cross-cultural communication must be instituted for all nursing cadres.

Furthermore, nursing management—informed by the Roy Adaptation Model—must address upstream organizational determinants, including chronic understaffing, excessive workloads, deficient infrastructure, and limited psychological resources. Cultivating supportive practice environments equipped with adequate rest periods, confidential counseling access, and spaces for meaningful patient-family interaction will mitigate compassion fatigue and foster holistic, dignified EOL care delivery.

CONCLUSION

This study demonstrates that nurses in academic hospital settings experience profound emotional and professional challenges during end-of-life care, characterized by feelings of inadequacy, grief, guilt, and emotional exhaustion. These challenges are not merely products of individual coping deficits, but are heavily driven by organizational failures including severe understaffing, inadequate psychosocial support systems, deficient palliative care training, and poor physical infrastructure.

Evaluated through Roy's Adaptation Model, these environmental stressors disrupt successful adaptation across physiological-physical, self-concept, role-function, and interdependence modes. Consequently, healthcare organizations must implement robust institutional support systems, expand palliative education curricula, scale up psychological counseling services, and upgrade clinical infrastructure. Meeting these structural demands will safeguard nursing well-being, enhance adaptive capacity, and ensure the delivery of compassionate, holistic, and dignified end-of-life care for patients and their families.

Recommendations

Clinical Practice

- **Psychosocial Support:** Implement systematic, routine psychological debriefing sessions, peer-support groups, and confidential professional counseling following emotionally taxing patient deaths.
- **Palliative Education:** Enhance continuous professional development programs focusing on symptom management, difficult family communication, grief processing, and ethical decision-making.
- **Communication Training:** Provide specialized communication workshops to prepare nursing

staff for managing sensitive prognostic disclosures and emotionally charged family dynamics.

- **Culturally Sensitive Care:** Integrate training in culturally congruent care to address linguistic and cultural diversity within academic hospital populations.

Administration

- **Administrative Programs:** Hospital administrators and nursing supervisors should establish dedicated institutional programs addressing the psychological trauma associated with frequent patient mortality.
- **Staffing Ratios:** Prioritize safe staffing ratios and optimal staff deployment to ensure adequate time for compassionate EOL care delivery.
- **Open-Door Policies:** Operational managers must foster supportive, open-door environments that encourage nurses to voice emotional distress without fear of reprisal.
- **Mentorship Initiatives:** Pair junior nursing staff with experienced palliative care mentors to guide them through initial clinical exposures to death and dying.

Policy

- **Comprehensive EOL Policies:** Academic hospitals should formulate robust, standardized EOL care policies encompassing advance care planning, bereavement support, family communication protocols, and clear nursing delineations.
- **Occupational Health Mandates:** Occupational health services must implement proactive mental health screening tools to identify and manage emotional distress and compassion fatigue among frontline personnel.
- **Formal Referral Pathways:** Establish transparent, confidential mental health referral pathways enabling distressed nurses to access specialized psychological care without administrative barriers.
- **National Standards:** Advocate for national policy frameworks mandating minimum standards for end-of-life nursing care, multidisciplinary collaboration, and palliative competency.

Use of Artificial Intelligence (AI) Declaration: The author declares that the data were not created, altered, or manipulated using generative artificial intelligence (AI) technologies. The reliability, credibility, and scientific content are entirely the authors' responsibility.

Acknowledgments: The author sincerely expresses gratitude to Sefako Makgatho Health Sciences University, the executive management of the academic hospital for granting research access, and the dedicated nurses who generously gave their time to participate in this study.

Authors' Contributions: **E.D.M**. is the sole author of this research manuscript, contributing entirely to conceptualization, methodology, formal analysis, investigation, writing, and review.

Data Availability Statement: The data supporting the findings of this study are available from the corresponding author, E.D.M., upon reasonable request.

Ethical Approval: Ethical approval was granted by the Sefako Makgatho Health Sciences University Research and Ethics Committee (Protocol: SMUREC/H/238/2025). Institutional authorization was obtained from the hospital CEO.

Informed Consent and Anonymity: Written informed consent was secured from all participants prior to data collection. Anonymity and confidentiality were protected by assigning alphanumeric pseudonyms *(e.g., Participant 1, Nurse A)* to all transcripts and reports, and restricting data access to the primary investigator.

Funding: This study received no external funding from public, private, or commercial institutions.

Conflicts of Interest: The author declares that they have no conflicts of interest.

ORCID iD:
Maphake, D.: https://orcid.org/0009-0009-2984-1720

Open Access: This original article is distributed under the Creative Commons Attribution Non-Commercial (CC BY-NC 4.0) license. This license permits people to distribute, remix, adapt, and build upon this work non-commercially and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made are indicated, and the use is non-commercial. See: https://creativecommons.org/licenses/by-nc/4.0/.

REFERENCES

Alshammari, F., Sim, J., Lapkin, S., & Stephens, M. (2022). Registered nurses' knowledge, attitudes and beliefs about end-of-life care in non-specialist palliative care settings: A mixed studies review. *Nurse Education in Practice*, *59*, Article 103294. https://doi.org/10.1016/j.nepr.2022.103294

Ayed, A., Sayej, S., Harazneh, L., Fashafsheh, I., & Eqtait, F. (2015). The nurses' knowledge and attitudes towards palliative care. *Journal of Education and Practice*, *6*(4), 91–99.

Barnard, N. B., Rothmann, S., De Beer, L. T., & Lubbe, W. (2023). Burnout of emergency nurses in a South African context: The role of job demands and resources, and capabilities. *Frontiers in Psychology*, *14*, Article 1119063. https://doi.org/10.3389/fpsyg.2023.1119063

Baqutayan, S. M. S. (2015). Stress and coping mechanisms: A historical overview. *Mediterranean Journal of Social Sciences*, *6*(2), 479–488. https://doi.org/10.5901/mjss.2015.v6n2s1p479

Bloomer, M. J., Ranse, K., Adams, L., Brooks, L., & Coventry, A. (2023). "Time and life is fragile": An integrative review of nurses' experiences after patient death in adult critical care. *Australian Critical Care*, *36*(5), 872–888. https://doi.org/10.1016/j.aucc.2022.09.008

Brink, H., van der Walt, C., & van Rensburg, G. (2018). *Fundamentals of research methodology for health care professionals* (4th ed.). Juta.

Clayton, M., & Marczak, M. (2023). Palliative care nurses' experiences of stress, anxiety, and burnout: A thematic synthesis. *Palliative & Supportive Care*, *21*(3), 498–514. https://doi.org/10.1017/s147895152200058x

Cybulska, A. M., Żołnowska, M. A., Schneider-Matyka, D., Nowak, M., Starczewska, M., Grochans, S., & Cymbaluk-Płoska, A. (2022). Analysis of nurses' attitudes toward patient death. *International Journal of Environmental Research and Public Health*, *19*(20), Article 13119. https://doi.org/10.3390/ijerph192013119

De Brasi, E. L., Giannetta, N., Ercolani, S., Gandini, E. L. M., Moranda, D., Villa, G., & Manara, D. F. (2021). Nurses' moral distress in end-of-life care: A qualitative study. *Nursing Ethics*, *28*(5), 614–627. https://doi.org/10.1177/0969733020964859

Dixon, E. L. (1999). An application of Roy's Adaptation Model to grief and bereavement. In C. L. Roy & D. A. Andrews (Eds.), *The Roy Adaptation Model: A guide for nursing practice* (pp. 125–140). Appleton & Lange.

Grove, S. K., Gray, J. R., & Burns, N. (2019). *Understanding nursing research: Building an evidence-based practice* (7th ed.). Elsevier.

Jung, M. Y., & Matthews, A. K. (2021). A systematic review of clinical interventions facilitating end-of-life communication between patients and family caregivers. *American Journal of Hospice and Palliative Medicine*, *38*(2), 180–190. https://doi.org/10.1177/1049909120929323

Kim, L. H., Kim, S. Y., Kim, S., Kim, H. A., Yang, H. J., Lee, K. M., Lee, S. Y., Lee, K. H., & Kim, J. H. (2021). A mixed method study for exploring the difficulties in end-of-life care and end-of-life care competency in nurses who take care of cancer patients. *Asian Oncology Nursing*, *21*(2), 98–109. https://doi.org/10.5388/aon.2021.21.2.98

Kostka, K., Tomczyk, M., & Kus, K. (2021). Professional burnout and moral distress among nurses providing palliative care. *Frontiers in Psychology*, *12*, Article 645123.

Limbu, T., & Taylor, P. M. (2021). Experiences of surgical nurses in providing end-of-life care in an acute care setting: A qualitative study. *British Journal of Nursing*, *30*(18), 1084–1089. https://doi.org/10.12968/bjon.2021.30.18.1084

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE.

Molefe, L. (2024). R425 first-year student nurses' experience of encounters with the death of a patient during clinical placement. *BMC Nursing*, *23*(1), Article 246. https://doi.org/10.1186/s12912-024-01922-z

Moses, A. C., Dreyer, A. R., & Robertson, L. (2024). Factors associated with burnout among healthcare providers in a rural context, South Africa. *African Journal of Primary Health Care & Family Medicine*, *16*(1), Article 4163. https://doi.org/10.4102/phcfm.v16i1.4163

Nacak, U. A., & Erden, Y. (2022). End-of-life care and nurses' roles. *The Eurasian Journal of Medicine*, *54*(Suppl. 1), S141–S145. https://doi.org/10.5152/eurasianjmed.2022.22324

Onah, S. I., & Oriekwo, C. (2024). *Effect of patient death on nurses* [Unpublished bachelor's thesis]. LABLAND University of Applied Sciences.

Owuor, R. A., Mutungi, K., Anyango, R., & Mwita, C. C. (2020). Prevalence of burnout among nurses in sub-

Saharan Africa: A systematic review. *JBI Evidence Synthesis*, *18*(6), 1189–1207. https://doi.org/10.11124/JBISRIR-D-19-00170

Paterson, L. A., & Maritz, J. E. (2024). Nurses' experiences of the family's role in end-of-life care. *Health SA Gesondheid*, *29*, Article 2565. https://doi.org/10.4102/hsag.v29i0.2565

Qutishat, M. (2025). Relationship between death anxiety and resilience among critical care nurses in Oman. *Nursing in Critical Care*, *30*(3), Article e13177. https://doi.org/10.1111/nicc.13177

Roy, C. (2009). *The Roy Adaptation Model* (3rd ed.). Pearson.

Roy, C., & Andrews, H. A. (1999). *The Roy Adaptation Model: A guide for nursing practice* (2nd ed.). Appleton & Lange.

Roy, C., & Roberts, S. L. (1981). *Theory construction in nursing: An adaptation model*. Prentice-Hall.

Shepherd, J. (2025). *The provision of end-of-life care in hospitals: Nurses' perceptions* (Doctoral dissertation, Open Research Newcastle). Newcastle University.

Üstükuş, A., & Eskimez, Z. (2021). The effect of death anxiety in nurses on their approach to dying patients: A cross-sectional study. *Perspectives in Psychiatric Care*, *57*(4), 1845–1852. https://doi.org/10.1111/ppc.12768

Xu, D. D., Luo, D., Chen, J., Zeng, J. L., Cheng, X. L., Li, J., & Hu, F. (2022). Nurses' perceptions of barriers and supportive behaviours in end-of-life care in the intensive care unit: A cross-sectional study. *BMC Palliative Care*, *21*(1), Article 130. https://doi.org/10.1186/s12904-022-01020-4

Young, C., & Roos, J. H. (2024). Factors that influence the quality of work life in nursing departments: A management perspective. *International Journal of Africa Nursing Sciences*, *20*, Article 100672. https://doi.org/10.1016/j.ijans.2024.100672

Zhang, X., Zhang, C., Gou, J., & Lee, S. Y. (2024). The influence of psychosocial work environment, personal perceived health and job crafting on nurses' well-being: A cross-sectional survey study. *BMC Nursing*, *23*(1), Article 373. https://doi.org/10.1186/s12912-024-02041-5